DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-015

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447, Subpart C

7. FEDERAL BUDGET IMPACT: *23,800 x 70.44%
a. FFY 2001 $ 16,765*
b. FFY 2002 $ Rates will be rebased

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Pages 6 through 10 and 13 through 35

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Pages 6 through 10 and 13 through 37

10. SUBJECT OF AMENDMENT:
Rates for nursing facilities effective October 1, 2000.

GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
William A. Prince

14. TITLE:
Director

15. DATE SUBMITTED:
December 18, 2000

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 26, 2000

18. DATE APPROVED:
March 8, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

Since the return on capital payment is provided as an incentive for the expansion of Medicaid services by the private sector, only those facilities that were established as profit earning centers were selected for the calculation of the base period costs. Non-profit facilities were excluded from the base period calculation.

2) Inflation Adjustment To Current Period "Deemed Asset Value"

The plan uses the index for the rental value of a home computed as part of the CPI as the appropriate measure for approximating the increase in the value of nursing home assets in South Carolina since 1980-1981. This index measures the increase in the amount that homeowners on average could get for renting their homes. For the period from 1980-1981 through the federal cost year 1998-1999, this index rose 131.56 percent.

Inflating the base period market value of $15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 1998-1999 is $36,165 per bed.

3) Calculation of "Deemed Depreciated Value"

The plan will exclude depreciation payments already received by operators from the Deemed Asset Value on the theory that the depreciation charges represent a reasonable valuation of the decline in the worth of the assets from old age. The result is the "Deemed Depreciated Value."

For a facility existing prior to July 1, 1989, the plan will continue to reimburse for actual depreciation costs based on a straight line apportionment of the original cost of the facility and the actual value of any additions. Effective October 1, 1990, for new facilities established or new beds entering the Medicaid Program on and after July 1, 1989, depreciation payments will be set based on actual construction costs, or the Deemed Asset Value when the facility begins operations, whichever is lower, and on applicable Medicare guidelines for depreciation. However, building depreciation for all new facilities/new beds on line on or after July 1, 1991 will be assigned a useful life of 40 years. Accumulated depreciation to be used to offset the deemed asset value for new facilities will be based on accumulated allowed depreciation (i.e. the lesser of actual depreciation or that determined by the Deemed Asset Value).

For bed increases of less than 50% (i.e. no six months cost report is filed), recognition of capital costs will be made at the point in time these beds are certified for Medicaid participation. Furthermore, that portion of the cost of

capital reimbursement applicable to these new beds will not be subject to the $3.00 cap.

In order to determine cost of capital reimbursement for these facilities, two cost of capital computations will be completed (for existing and new beds). To determine an equitable capital reimbursement, a formula determination for the new beds utilizing annualized data will be computed and then weighted with the values calculated for the existing beds. The weights will be projected utilization of existing and new beds during the rate cycle, with minimum occupancy being 96%.

The actual cost of any additions to new beds after July 1, 1989 will be added to the Deemed Asset Value for the purpose of computing depreciation charges. For clarification purposes, any capital expenditures incurred after the certification date of the new beds during the initial cost report period will not be considered as improvements, but as part of actual construction costs.

For facilities where there are no historical costs available, the plan computes a Deemed Depreciated Value based on the Base Period Asset Cost, adjusted to the year of construction using the index for home owner's rent, spread over a depreciation period applicable to the year of construction under Medicare guidelines.

The allocation of the base 1981 nursing home bed cost ($15,618) by component is as follows:

Asset Component	Cost Per Bed	Percentage of Total
Land	$ 461	2.95%
Building	12,274	78.59%
Equipment and Other	2,883	18.46%
Total	$15,618	100.00%

A useful life of 40 years will be assigned to the building and a composite useful life of 12 years will be assigned to the equipment and other.

4) Determination of the Market Rate of Return

The plan provides the lowest rate of return to investors that would provide incentives to keep the industry expanding sufficiently to meet the growing needs of Medicaid patients. The industry may need approximately three to four million dollars per year of new investments to keep up with the growing population and the demand for Medicaid services in the near future.

In determining that rate of return, the question is, "where can that money be raised and what rate of return will be necessary to raise that kind of money." Part of the funds

could be raised by borrowing from the banks. But this would be rather costly for the small investor, who would probably have to pay a rate of interest in excess of the prime rate.

The plan sets the rate of return for a fiscal year at the average of rates for thirty year treasury bonds for the latest three completed calendar years prior to the fiscal year, as determined by the Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective October 1, 2000, this rate is 6.0%.

Acknowledging a newly constructed facility's plight of high per bed construction costs and interest rates as great and greater than the market rate of return, the rate of return for these facilities will be the greater of the interest rate incurred by the facility or the industry market rate of return as determined by the Budget and Control Board. These facilities will only be allowed their interest rate (if greater) during a transition period which is defined as the rate period beginning with the facility's entrance into the Medicaid program and ending at that point in time in which the facility files its first annual FYE September 30 cost report that will be used to establish the October 1 rate (i.e. period ends September 30). In no circumstances will the allowed interest rate exceed 3% above the industry market rate of return.

5) Additions To Facilities After 1981

The plan intends to provide adequate incentives for the expansion of nursing home services by the private sector of the state. The Deemed Depreciated Value takes into account the wearing out of facilities, but does not include any factor for additions or upgradings to the facilities. Operators who have made capital improvements to their facilities since 1981 are permitted to add the amount of the investment to their Deemed Asset Value. Operators are also permitted to add the cost of future additions and upgradings of facilities to their Deemed Asset Value. This provision will provide an incentive to operators to reinvest part of their cash flow back into the facility to maintain and improve the level of service provided by the operator. For clarification purposes, capital expenditures incurred by new beds on line on or after July 1, 1989 during the initial cost reporting period will not be considered as improvements, but as part of actual construction costs.

6) Computation of Cost of Capital

The cost of capital for each patient day served would be calculated for each nursing home based on the Deemed Asset Value. The computation of the rate of reimbursement for the cost of capital is illustrated below in Table 1 for the

average facility of 100 beds, based upon federal cost year 1987-1988, which is used for computing state fiscal year rates effective July 1, 1989. In this illustration, the average accumulated depreciation for the industry is used to compute an average Deemed Depreciated Value. Under the plan, each operator will use the accumulated depreciation applicable to his own facility to calculate the Deemed Depreciated Value of his facility. Beginning in federal cost year 1987-1988, which was used for computing state fiscal year 1989-1990 rates, the Deemed Asset Value was set at $23,271 for each bed.

The Deemed Asset Value of the facility would be the fixed $23,271 per bed multiplied by the number of beds, which would amount to $2,327,100 for the average 100 bed facility. To determine the amount of Deemed Depreciated Value for an individual facility, the amount of depreciation costs the provider has reported in accordance with Medicare/Medicaid guidelines would be subtracted from the Deemed Asset Value of the facility and the value of improvements added to the Deemed Asset Value. The average amount of accumulated depreciation for a 100 bed facility is $356,827.

The estimated Deemed Asset Value of the facility less the accumulated depreciation would yield an average Deemed Depreciated Value of $1,970,273 for this average facility. In this example, improvements were assumed to be zero, but an operator would add on the value of any improvements.

At the July 1, 1989 market rate of return of 9.8 percent the annual return would be $193,087. At July 1, 1989, the total capacity of 36,500 patient days for the facility less the two percent turnover factor, would yield a facility capacity factor of 35,770 patient days. Actual patient days will be used if actual occupancy exceeds 98 percent. Effective October 1, 1995, minimum occupancy is established at 97%. Effective October 1, 2000, the minimum occupancy is established at 96%. This would yield a payment by the State of $5.40 per patient day for each day of Medicaid service. The annual return for the facility will replace facility lease costs and capital interest costs (excluding specialty vehicle interest which is directly charged to the appropriate cost center) reflected under the cost of capital cost center. Lease costs associated with equipment rentals (separate from a facility lease) will be reflected in the affected cost centers.

Table 1

METHOD FOR CALCULATING COST OF CAPITAL REIMBURSEMENT
EFFECTIVE JULY 1, 1989

Original Asset Cost 1980/1981	$ 15,618
Inflation Adjustment to Cost Year 1987-1988	X 1.49
Deemed Asset Value FY 87-88	$ 23,271
Number of Beds	X 100
Deemed Asset Value of Facility	2,327,100
Improvements Since 1981	0
Accumulated Depreciation	(356,827)
Deemed Depreciated Value	1,970,273
Market Rate of Return	X 9.8%
Annual Return for Facility	193,087
Facility @ 98% Capacity*	35,770
Return per Bed per Patient Day	$ 5.40

*Effective October 1, 1995, minimum occupancy is established at 97%.
*Effective October 1, 2000, minimum occupancy is established at 96%.

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SUPERSEDES: MA 99-012

The extraordinary costs incurred by nursing facilities would include the costs of transporting residents, the costs of housing the nursing facility residents in facilities other than long term care institutions, and the costs associated with housing the nursing facility staff which were taking care of the residents offsite.

In order for a nursing facility to request payment from this pool, the facility must submit copies of invoices and canceled checks relating to the extraordinary costs defined above. The nursing facility must also provide a copy of the census report(s) relative to the offsite stay, and identify the Medicaid recipients. Additionally, the nursing facility must report any insurance proceeds received from "business continuance" or "business interruption" insurance policies, or FEMA proceeds. These proceeds will be used to reduce any extraordinary costs claimed by the nursing facility.

Once the amount of unreimbursed extraordinary costs have been determined, the SCDHHS will determine Medicaid's share by applying the Medicaid utilization percentage determined from the census reports applicable to the offsite stay against the unreimbursed cost. Payment will be made to the provider via an adjustment. The costs associated with the extraordinary costs paid under this arrangement can not be included as allowable Medicaid costs in future cost reporting periods.

To be considered for this one time payment, all requests must be sent to the Bureau of Reimbursement Methodology and Policy at the following address:

South Carolina Department of Health and Human Services
Bureau of Reimbursement Methodology and Policy
Post Office Box 8206
Columbia, South Carolina 29202-8206

IV. Payment Determination

The rate cycle will be October 1 through September 30 and will be recomputed every twelve (12) months, utilizing the cost reports submitted in accordance with Section I, Cost Finding and Uniform Cost Reports, of the Plan.

Rates effective October 1, 1999 through September 30, 2000 will be recomputed annually based on the percentage of Level A Medicaid patients plus the Medicare co-insurance days for dual eligibles served by the facility. The DHHS Aries report reflecting nursing facility utilization by patient acuity based on January through June 1999 data will be used for the October 1, 1999 rates. Rates effective on or after October 1, 2000 will be computed annually using the DHHS Aries report reflecting nursing facility utilization by patient acuity based upon the preceding July 1 through June 30 data period.

A. REIMBURSEMENT METHODOLOGY TO BE USED IN THE CALCULATION OF THE MEDICAID REIMBURSEMENT RATES

A prospective rate shall be established for each nursing facility separately based on the facility's cost report, and upon the standard costs which are developed in accordance with the methodology described below. In the event that audit adjustments are made to cost reports in accordance with Title XIX and Title XVIII Program rules, regulations, policies and procedures, the rate of payment will be established so as to be consistent with the facility's cost as audited. In the event that such adjustment is made subsequent to the date that a facility was paid an incorrect rate based on unaudited costs, the facility will be liable to repay to the South Carolina Department of Health and Human Services the difference between the audited rate and the interim rate for the contract period. In a case in which an audited rate exceeds the interim rate, the South Carolina Department of Health and Human Services will be liable to repay the facility the difference between the audited rate and the interim rate for the contract periods beginning on or after October 1, 1994.

Effective October 1, 1995, nursing facilities which do not incur an annual Medicaid utilization in excess of 1,000 patient days will receive a prospective payment rate which will represent the average industry rate at the beginning of each rate cycle. The average industry rate is determined by summing the October 1 rate of each nursing facility and dividing by the total number of nursing facilities. This rate will not be subject to change as a result of any field audit, but will be subject to change based on the lower of cost or charges test to ensure compliance with the state plan.

PROVIDER NAME:
PROVIDER NUMBER:
REPORTING PERIOD: FYE 9/30/99

REFERENCE #
DATE EFF. 01-Oct-00

NURSING FACILITY
TOTAL PATIENT DAYS: # CODE
TOTAL PROVIDER BEDS: 1

% OCCUPANCY 0.00%

% LEVEL A

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

	PROFIT INCENTIVE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		0.00	0.00	
DIETARY		0.00	0.00	
LAUNDRY/HOUSEKEEPING/MAINT.		0.00	0.00	
SUBTOTAL	0.00	0.00	0.00	0.00
ADMIN & MED REC	0.00	0.00	0.00	0.00
SUBTOTAL	0.00	0.00	0.00	0.00
COSTS NOT SUBJECT TO STANDARDS:				
UTILITIES		0.00		0.00
SPECIAL SERVICES		0.00		0.00
MEDICAL SUPPLIES AND OXYGEN		0.00		0.00
TAXES AND INSURANCE		0.00		0.00
LEGAL COST		0.00		0.00
SUBTOTAL		0.00		0.00
GRAND TOTAL		0.00		0.00
INFLATION FACTOR 3.20%				0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)				0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				0.00
EFFECT OF $1.75 CAP ON COST/PROFIT INCENTIVES				0.00
NURSE AIDE STAFFING ADD-ON 10/01/2000				0.00
NURSE AIDE STAFFING ADD-ON 10/01/1999				0.00
REIMBURSEMENT RATE				0.00

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SUPERSEDES: MA 99-012

Effective October 1, 1995, for the purpose of establishing all cost center standards, the facilities are grouped according to bed size. The bed groupings are:

0 Through 60 Beds
61 Through 99 Beds
100 Plus Beds

B. ALL STANDARDS, EXCEPT FOR GENERAL SERVICES, FOR PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED) WILL BE COMPUTED USING PROPRIETARY FACILITIES ONLY. EFFECTIVE OCTOBER 1, 1997, HOSPITAL BASED PROPRIETARY NURSING FACILITIES WILL BE EXCLUDED FROM THE COMPUTATION OF ALL STANDARDS, EXCEPT FOR GENERAL SERVICES. THE GENERAL SERVICE STANDARD WILL BE COMPUTED USING PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED). A BRIEF DESCRIPTION ON THE CALCULATION OF ALL THE STANDARDS IS AS FOLLOWS:

1. General Services:

a. Accumulate all allowable cost for the General Services cost center (Nursing & Restorative) for all facilities in each bed size.

b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 96%).

c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).

d. Calculate the standard by multiplying the mean by 105%.

e. The establishment of the General Services standard for all nursing facilities (excluding state owned facilities) will be based on the average of the percentage of Medicaid Level A patients/total Medicaid patients served. Rates effective October 1, 1999 through September 30, 2000 will be recomputed annually based on the percentage of Level A Medicaid patients plus the Medicare co-insurance days for dual eligibles served by the facility. The DHHS Aries report reflecting nursing facility utilization by patient acuity based on January 1999 through June 1999 data will be used for the October 1999 rates. Rates effective on or after October 1, 2000 will be computed annually using the DHHS Aries report reflecting nursing facility utilization by patient acuity based upon the preceding July 1 through June 30 data period. The General Services standard for each separate facility will be determined in relation to the percent of Level A Medicaid patients served, i.e., the base standard determination in (d.) above will be decreased as the percent of Level A Medicaid patients is decreased and increased as the percent of Level A Medicaid patients is increased.

2. Dietary; Laundry, Maintenance and Housekeeping; Administration and Medical Records & Services: The standard for each of these three cost categories is calculated as follows:

   a. Accumulate all allowable cost for each cost center for all facilities in each bed size.

   b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 96%).

   c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).

   d. Calculate the standard by multiplying the mean by 105%.

C. RATE COMPUTATION:

Rates will be computed using the attached rate computation sheet (see page 15) as follows:

1. For each facility, determine allowable cost for the following categories:

   COST SUBJECT TO STANDARDS:

   General Services
   Dietary
   Laundry, Maintenance and Housekeeping
   Administration and Medical Records & Services

   COST NOT SUBJECT TO STANDARDS:

   Utilities
   Special Services
   Medical Supplies
   Property Taxes and Insurance Coverage - Building and Equipment
   Legal Fees

2. Calculate actual allowable cost per day based on the cost reports for each category by dividing allowable cost by actual days. If the facility has less than 96% occupancy, actual days will be adjusted to reflect 96% occupancy.

3. For cost subject to standards, the lower of cost determined in step 2 or the cost standard will be allowed in determining the facility's rates. Effective October 1, 1997, the General Services, Dietary, and Laundry, Housekeeping, and Maintenance cost centers are combined. Therefore, compare the sum of the allowable cost of these three cost centers to the sum of these three cost standards.